



<Date>

I.D. #: \*SSN\*

NAME  
ADDRESS  
CITY, STATE ZIP

Dear NAME:

Basic Health (BH) is required by state law to verify that members' account information is current. We have mailed you notices requesting information to verify that you and your covered family members are eligible for BH, and that your premium is correct. Either the requested information has not been received, or the information you sent was not complete.

**As a result, BH coverage for the family member(s) listed below will end effective 12:01 a.m., <date>.**

<name>

You may not be eligible to re-enroll in BH for at least 12 months from the date your coverage ends and may also have to wait until space is available.

Family members enrolled in Basic Health *Plus* or the Maternity Benefits Program will continue to receive benefits as long as they remain eligible for these programs. Changes in circumstances for family members enrolled in these programs may be reported to the Department of Social and Health Services.

If you disagree with a decision made by BH, or believe an action taken on your account was incorrect, please refer to the enclosed letter for complete instructions on how to resolve the issue. Please be sure to follow the instructions completely to maintain your appeal rights.

To help in your search for new health care coverage, please refer to our Web site at **[www.basichealth.hca.wa.gov](http://www.basichealth.hca.wa.gov)** and select "Other health care coverage options."

If you have questions, please call us at **1-800-660-9840**.

Sincerely,

*Basic Health*  
*Customer Services*

Enclosure

Washington State Health Care Authority  
P.O. Box 42683 • Olympia, WA 98504-2683  
1-800-660-9840 • FAX 360-923-2610 • TTY 360-923-2701 or Toll-free 1-888-923-5622 • [www.basichealth.hca.wa.gov](http://www.basichealth.hca.wa.gov)